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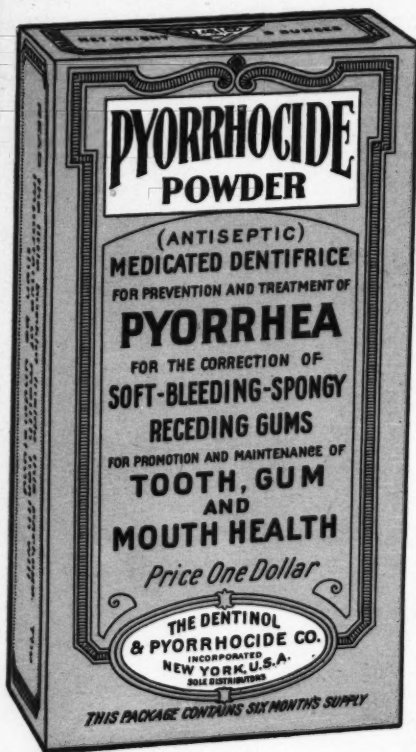
ORAL HYGIENE

AUGUST ~ *A Journal for Dentists* ~ 1924

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AUGUST, 1924

VOL. XIV, No. 8

Yesterday! Today! Tomorrow!

By W. H. RICHARDS, D.D.S., 50 years in practice

YESTERDAY!

As I sit and dream in the fireside's glow
Of those I loved so long ago,
I live again in Olden Days,
Retracing paths of childhood's ways;
Through these mem'ries my thoughts roam,
Revive each scene of my childhood home—
Reincarnated, each absent face
Which then I loved in that hallowed place!

TODAY!

But Time has ordained that my clay must
Release its soul—return to dust;
My wrinkled brow and furrowed face
All but bespeak the passing phase,
My tottering steps, my palsied hands,
My toothless smile, my withering glands,
Give evidence—as for me—
I, too, shall soon a memory be!

TOMORROW!

Of tomorrow? Nought have they written who have passed
along,
Though Earth's greatest are in that throng;
Nor can they utter one word of cheer
To lighten our way in that world so drear!
Yet, is the voyage not obscure nor dark?
Hark! What's that melody? Like the lark
God's voice has proclaimed:
"Come unto Me, ye halt and maimed,
Sick and afflicted, sad and worn,
From you Earth's miseries shall be shorn;
Ye who have labored and stood the test,
Come unto Me. I will give you rest!"

Studies in

Periodontal Pa



FEW months ago, there was published in the Toronto press an announcement which was copied with more or less mutilation over the length and breadth of the United States and Canada, to the effect that Dr. Harold Keith Box of Toronto had made some startling discoveries about "pyorrhea alveolaris." In these newspaper articles it was alleged that he had discovered the "*cause of Pyorrhea*," that he had discovered "*the germ of pyorrhea*," that he had discovered "*the cure of pyorrhea*," and so on. Very few of the newspaper stories actually told what he had discovered, so prone is the reportorial mind to wander into the by-paths of near fact and fancy, especially when the subject is highly technical. Because of the garbling of facts by the papers and because Dr. Box's work is comparatively unknown to the rank and file of the dental profession in the United States, it has seemed fitting that some authoritative announcement should be made to the dental profession pending the publication of Dr. Box's recent work in one of the American dental journals.

IT HAS been our privilege to be closely associated with Dr. Box for several years. We have watched his work with ever-increasing admiration, and with the realization that through his ability in research, the problem of periodontal disease, which has so long baffled our profession, would shortly be solved. And it is our pleasure to be authorized to present this statement.

We believe the dental profession will, first of all, be interested regarding Dr. Box himself. He is a young man in his early

thirties, but a man who has for years been recognized by those who have been in close touch with dental research work as an outstanding figure in this field.

Soon after he graduated he won the prize in dental research at the Royal College of Dental Surgeons in Toronto.

In 1920 the University of Toronto conferred on him the degree, Doctor of Philosophy, his thesis being on Dental Pathology. So far as is known, that was the first time the degree Ph. D. had ever been awarded on the preliminary qualification of

**PAUL R. STILLMAN, D.D.S., F.A.C.D., F.A.A.P., and
JOHN OPPIE McCALL, B.A., D.D.S., F.A.A.P.**

**An Appreciation of the Researches of Harold Keith Box,
D.D.S., Ph. D., F.A.A.P.**

Pathology

Doctor of Dental Surgery. It is the almost universal custom of universities to require the preliminary degree, Bachelor of Arts, or of Science, before granting the degree of Philosophy.

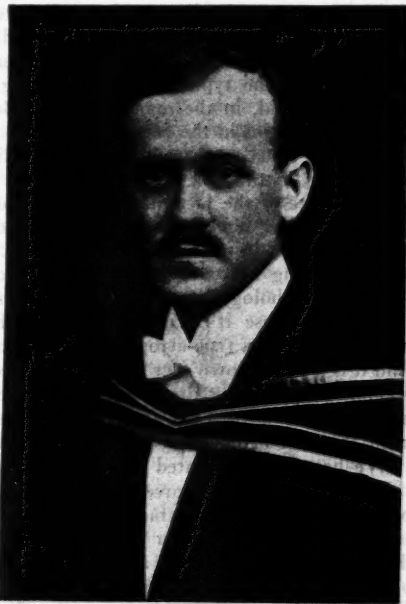
Having this award go to a dentist was an honor to all dentists. And, in earning the right to this honor, Dr. Box conferred honor upon all who hold the degree, Doctor of Dental Surgery. For through the establishment of this precedent, the degree D. D. S. was given recognition as being an equivalent to Bachelor of Arts.

In 1921 Dr. Box was chosen as its "First Fellow" by the American Academy of Periodontology.

He has for several years been professor of dental pathology and of periodontology in the Royal College of Dental Surgeons in Toronto. He was also sometime instructor in the advanced courses in dentistry given by

Columbia University in New York City.

What Dr. Box has recently discovered is a new disease—new not only in dental pathology, but in general pathology as



Keystone Photo

He is a young man in his early thirties, but a man who has for years been recognized by those who have been in close touch with dental research work as an outstanding figure in this field.

well. After consultation with Dr. Oskar Klotz, professor of pathology in the University of Toronto, and several other well-known pathologists, he gave it the name, *Rarefying Pericementitis Fibrosa*. This is the primary lesion of so-called "pyorrhea alveolaris." In other words, it precedes bone resorption, pocket formation and even gingivitis. It is a *mildly inflammatory* but *non-infective* fibrosis of the pericementum, producing rarefaction of the adjacent alveolar wall. An analysis of this statement reveals several important points. In the first place, this disease does not manifest, in itself, the typical signs of infection, and, in the majority of cases, begins in the pericementum previous to the advent of infection in the gingival tissue. In spite of the fact that it is not infective, it exhibits evidence of a mild inflammation. Without going into the technicalities of pathology, it may be said that because it is inflammatory, it is not a true atrophy. And it is a well-known fact that inflammatory diseases are much more hopeful as regards treatment than are atrophic diseases.

We have already stated that this pericemental lesion precedes bone resorption, and in fact *is itself* the active factor in producing resorption of the alveolar bone. This is a point of the first importance, both in the consideration of the purely theoretical aspects of periodontal disease and in the consideration of those practical aspects connected with treatment.

In a bulletin recently published by the Canadian Dental Research Foundation* this new disease is fully described and illustrated by numerous photomicrographs. In it Dr. Box also presents a full exposition of his views as to the sequence and nature of the pathologic changes leading to the development of a mature case of what has in the past been commonly called "pyorrhea alveolaris." In this presentation he makes use of a nomenclature containing several new terms, which seem to be well suited to the designation of the conditions of disease as described and as shown in the photomicrographs.

Dr. Box has found that there are two distinct types of periodontal disease, or chronic periodontitis, as he terms it. These are chronic periodontitis simplex and chronic periodontitis complex. The "complex" type is the common type and is characterized in the mature case by the formation of deep pus-pockets along one or more sides of the root, as contrasted with the type which produces uniform resorption of the alveolar crest. To this type he gives his main consideration in the bulletin.

Chronic periodontitis complex is, as its name indicates, a complex disease. It is produced through the coalescence of several more or less distinct diseases, each having a certain se-

* "Studies in Periodontal Pathology." (\$1.) Bulletin No. 7, Canadian Research Foundation, 240 College St., Toronto.

quence as regards its appearance in the cycle. The first disease, in the order of appearance is (1) *Rarefying Pericementitis Fibrosa*, whose effects on the pericementum and alveolar process have already been described. The second disease is (2) *Chronic Gingivitis*. This condition is added to, and has its course, as it were, parallel to the fibrosa, having been influenced on its incidence by the fibrosa. With chronic gingivitis comes incipient pocket formation occurring at the base of the gingival crevice. Following this comes the third disease (3) *Chronic Pericementitis*, with extension of the pocket into the pericementum. It is superimposed on the chronic gingivitis and is fused with it. Due to the fact that the primary fibrosa has caused the absorption of alveolar bone previous to the advent of the pocket into the pericementum, there is no direct involvement of the bone through the formation of the pocket. Nor is there, at this stage, any evidence of infection in the bone which is undergoing resorption. Later, however, with the extension of the pocket toward the apical portion of the root, infection does find its way into the bone and the fourth disease becomes manifest, viz., (4) *Infective Osteitis*. This in its turn becomes superimposed upon and fused with the chronic gingivitis and the chronic pericementitis.

These four diseases can be distinguished from each other, yet they merge together to produce the typical fully developed lesion

of advanced periodontoclasia.

We have made the statement* that the discovery of the rarefying pericementitis fibrosa was as epoch-making as was Miller's discovery of the relationship of carbohydrate fermentation to the production of caries. At first glance this seems a sweeping statement, but we believe that the verdict of the future will bear out our claim.

It will be recalled that Miller's researches demonstrated that fermentations of starches and sugars, with resultant formation of organic acids, would under certain conditions produce decalcification of enamel and initiate caries. By his work in this field, he did two things—he demonstrated the actual starting point of the carious process, and pointed out *one* of the factors responsible for the lesion; and he also disproved various other theories of caries which had caused confusion in our profession previous to his discovery. That he did not entirely solve the problem of caries is well known, and it is the loss of the entire dental profession that Miller could not have been spared to carry on his investigations.

Just as Miller demonstrated the actual starting point of caries and the agency responsible for the loss of enamel substance, so Dr. Box has demonstrated the starting point of chronic periodontitis complex and the agency responsible for the initial loss of

* In a memorial addressed to Hon. Forbes Godfrey, M. D., Minister of Health of the Province of Ontario, on the occasion of his announcement to the public of Dr. Box's discovery.

alveolar bone. And he has at the same time effectually disposed of the theories of primary alveolar atrophy and primary infection of the gingivae as the initial lesions in this type of periodontal disease. Dr. Box makes no claim that he has at the present time completely solved the problem of so-called "pyorrhea." But the first great step has been taken, and we know that there is much to follow from the same source.

It will be recalled that for many years controversy has raged as to whether periodontal disease was of "local" or "systemic" origin. It will be remembered that parallel to this there has been a minor controversy carried on as to whether the initial lesion was located in the gingiva and was infective in its nature, or whether the first lesion was in the alveolar bone and was atrophic in character. Dr. Box has settled both of these controversies. The point of origin we have already discussed. With regard to the question of "local" or "systemic" etiology, Dr. Box has made no extended public comment. Study of the bulletin containing his recent work, just published, forces the conclusion that the main or primary etiological factor in the evolution of rarefying pericementitis fibrosa is a mechanical irritant acting on the entire pericementum, modified in its manifestations in many cases by systemic factors still to be analyzed. In other words, it is evident that traumatic occlusion, in the majority of cases, is a primary localizing

factor, and that systemic factors, if present, follow traumatic occlusion, modifying the clinical picture of the lesion. And, in fact, this view, brief and incomplete as it is, is substantiated by Dr. Box himself. He furthermore has stated to us that undoubtedly the best way to prevent the incidence of fibrosa of the pericementum is by so adjusting the occlusion that the stress to which each tooth is subjected will be within the normal range for the supporting tissues of that tooth. Such a relation he calls *physiologic* occlusion.

As to the other aspects of etiology, Dr. Box has mentioned the disbalance of calcium metabolism as a possible contributing factor in the resorption of alveolar bone. Since the resorption of bone is invariably preceded by rarefying pericementitis fibrosa, he has made it clear that he considers disturbed calcium metabolism to be a *secondary* and not a primary factor in etiology.

This is further borne out by our own clinical observation. We have often called attention to a phenomenon of common occurrence, viz., that in every case of periodontal disease there is an uneven distribution of the disease process. Some teeth show in radiograms practically normal supporting bone, others show various stages of bone resorption, and frequently no bone resorption whatsoever is to be found in other parts of the same mouth. Dr. Box agrees with our contention, that if the "systemic" factor, whatever it may

Cardboard Reprints of Dr. Box's "Twenty Signs" Available

At the authors' suggestion, we have printed Dr. Box's Twenty Signs of Periodontal Disease as complete pages, 1370 and 1371, so as to facilitate reference to this information.

These two pages will also be printed upon heavy cardboard and may be had upon request, without charge; requests should be addressed "Oral Hygiene, Publication Office, Pittsburgh, Pa.," rather than to the editor's office.

be, were the primary one, resorption of the alveolar bone would be inaugurated simultaneously and symmetrically in *all parts of the mouth*.

Infection, which usually makes its appearance in the gingiva after the pericemental and alveolar lesion is well established, is an etiological factor of great importance, in that it affects profoundly the course of development of the disease. But this, too, is secondary in the etiology of periodontitis complex, although occupying clinically so prominent a place in the mature lesion.

As regards treatment, Dr. Box has made no public statement. But we are authorized to state that adjustment of occlusion has a prominent part in the treatment of cases having periodontitis complex, together with removal of such deposits as may be found and the institution of measures to raise local resistance to infection. This latter point

he considers very important and suggests that there may soon be resources available in this field which have not been as yet sufficiently developed.

Perhaps the most important message in this bulletin of Dr. Box's is the prominence which is inevitably given to the recognition of the early signs of periodontal disease, and his plan for the institution of preventive treatment when any of these signs are observed.* When it is realized that as soon as the shallowest pocket is found, the evidence is that disease has already been established for a considerable length of time and has involved the pericemental and alveolar tissues, the significance of the early sign of disease is thus made clear. This bulletin gives a list of 20 signs of early periodontal disease. They are reprinted here as follows:

* "Signs of Incipient Periodontal Disease," in Bulletin No. 7, Canadian Dental Research Foundation.

SIGN No. 1. Traumatic Crescent. A crescent-shaped zone of abnormally deep color, never extending completely across the gingival border of the tooth, and being confined, as a rule, to a segment about one-sixth of the circumference of the root. It may be superimposed over a mild generalized gingivitis, but frequently occurs in an otherwise healthy gingiva. It is considered to be a sign of a localized circulatory disturbance in the pericementum, and is, as a rule, associated with traumatic occlusion.

SIGN No. 2. Congestion of Marginal Gingiva. This zone of congestion extends completely across the gingival border of the tooth. It is regarded as a sign of generalized pericemental circulatory disturbance. It is commonly found in cases exhibiting an end-to-end occlusion.

SIGN No. 3. Mobility No. 1. This is a degree of mobility so slight as to escape casual observation. It requires careful manipulation and the application of considerable digital pressure, in many instances, for its detection. It seems to be associated with rarefying pericementitis fibrosa, since, in this disease, varying numbers of the pericemental fibres have been replaced by this soft, yielding, new tissue.

SIGN No. 4. Recession of the Marginal Gingival Line. Taking the amelo-cemental junction as a fixed landmark, it is often found that the gingival margin shows an altered relationship to this line. In the average case the margin of the gingiva is approximately two millimeters above the amelo-cemental line. Recession of the gingival margin toward this line is usually indicative of alveolar crest resorption. For example, a recession of the marginal gingiva which just exposes the amelo-cemental line will probably indicate a crest resorption of two millimeters. Exposure of the cementum will indicate an increased alveolar resorption of a corresponding degree.

SIGN No. 5. Asymmetric Recession of the Marginal Gingival Line. In many cases recession of the gingi-

val margin involves only part of the normal gingival line. This may occur in the median line of the tooth or on either side of this line, thus disturbing the normal symmetry of the curve of the gingival margin. It indicates a localized resorption of the alveolar crest.

SIGN No. 6. Recession of the Alveolar Crest Line. The crest of the alveolar process in the average normal case is approximately two millimeters below the amelo-cemental line, which has been adopted as a fixed landmark. Disturbance of the normal relationship between these lines is a manifestation of recession of the alveolar crest line. This may usually be detected by careful study of the radiograph.

SIGN No. 7. Increased Radiolucency of the Alveolar Crest or Lamina Dura. This is an indication of a rarefaction of the alveolar bone in these locations.

SIGN No. 8. Disturbance of Normal Contour of the Alveolar Crest. Frequently the alveolar crest presents in the radiograph a slightly eroded appearance, disturbing its characteristic normal symmetry. This is due to a localized resorption of the alveolar crest.

SIGN No. 9. Increased Widening of the Pericemental Space. When complete rarefaction of the lamina dura takes place there is exhibited in the radiograph, in certain zones, a definite widening of the line which represents the pericemental space.

SIGN No. 10. Mobility No. 2. When the lamina dura is destroyed to any extent about the tooth there is, of course, an increase in the soft tissue content between the tooth and the remaining alveolar wall. This naturally permits an increased mobility beyond the normal and beyond that designated as Mobility No. 1.

SIGN No. 11. Shortening of the Crest of the Septal Gingiva. When an appreciable resorption of the septal alveolar crest has occurred there will usually take place a concomitant dropping away of the septal gingiva. This will be evidenced clinically by the appearance of spaces between the teeth which

were formerly filled with gingival tissue.

SIGN No. 12. Linear Depressions in the Alveolar Mucosa. These lines are often better shown on models than in the mouth, but may usually be demonstrated in the mouth if the light is properly directed and the mucous membrane is dried. They extend parallel to the long axis of the root and overlie the septal bone. These depression lines are to be differentiated from the normal depressions between the alveoli of adjoining teeth. These lines are characterized by being sharply drawn.

SIGN No. 13. Stillman's Clefts. These are clefts occurring in the gingival border, occasionally in the center line of the tooth, but more commonly to one side of this line. Two clefts are frequently noted on the same tooth. Although the underlying tooth surface may not be visible, due to the apposition of the divided tissue, it is invariably possible to pass an instrument through any portion of the cleft to the tooth surface. The writer regards these clefts as essentially small pockets in which the ulcerative process has extended through to the labial surface of the gingiva.

SIGN No. 14. Absence of Stippling. In the normal gingiva the color is not a uniform pink, but presents a translucent stippled appearance of alternating spots of lighter and darker shade. When the normal gingiva is dried it presents a somewhat velvety or mossy surface, indicative apparently of a normal circulation in the capillary loops. There is frequently observed a condition in which this mossy, stippled appearance is lost, and the surface is shiny, even when dried, and of a uniform color. The author considers this usually to be a sign of oedema in the gingiva.

SIGN No. 15. Festoons. When, through the action of a certain grouping of etiologic factors, a hyperplasia of the marginal gingiva is induced, it is frequently manifested clinically by the occurrence of a linear depression outlining the marginal gingiva. The marginal

gingiva presents a characteristic uniform thickening, which, however, in the early stages, does not involve the margin itself. In the early stages, too, there is no deviation from the normal color. McCall has called attention to the frequent relationship between these festoons and traumatic occlusion.

SIGN No. 16. Injection of Blood-Vessels in the Marginal Gingiva. With the aid of an ordinary magnifying glass there is to be seen, in many cases, a typical dilation of the blood-vessels in the gingival margin. This is to be considered as an indication of early infection in the marginal gingiva.

SIGN No. 17. Increased Depth of the Gingival Crevice. The normal gingival crevice measures in the average case approximately two millimeters. Any increase in its depth beyond this point must be regarded with suspicion. It is to be regarded as a sign of early pocket formation in the cemental gingiva. This lesion is to be detected only by the use of a suitable diagnostic probe.

SIGN No. 18. Epithelial Nodules. There are occasionally to be seen on the surface of the gingivae small, slightly elevated nodules. They are of a lighter color than the surrounding tissue and in shape are usually round or oval. They usually indicate a period of long-standing venous congestion.

SIGN No. 19. Distended Veins in the Mucosa. In many cases there are to be observed dilated blood-vessels of a purplish color, arising in the septal cemental gingiva, and traceable for a considerable distance in the alveolar mucosa. They usually indicate the establishment of infection in the cemental gingiva at the base of the interproximal crevice.

SIGN No. 20. Pus-Cells in the Crevicular Exudate. Frequently, when clinical signs of pus are lacking, and the gingival crevice is of normal depth, a microscopic examination of the crevicular fluid will reveal the presence of pus-cells. This may safely be regarded as evidence of a suppurative gingivitis.

The above contribution alone makes Dr. Box's message of paramount importance to every dentist who desires to see the teeth and their supporting structures preserved in a state of health. Periodontists have become familiar with many of these signs and they recognize them for what they are. But never before has there been such a complete list offered for study. Here, then, is an authoritative chart by the means of which the

course of preventive dentistry may be plotted. Every dentist ought to have this list framed and placed before him for reference each time he examines a patient's mouth.*

In conclusion, let us state once more our deep sense of the obligation Harold Keith Box has put upon the dental profession by his wonderful contribution in the field of periodontal research.

* This is a hint to the Editor, e. g., print on one page (or two) so that the pages can be cut out and framed.

High Praise for "Dr. Pepys"

CHICAGO DENTAL SOCIETY

Office of Secretary.

Dear Doctor McGee:

Many of our members always read "Pages from the Diary of a Modern Samuel Pepys," and much favorable comment has been heard from them on the manner in which the January meeting of the Chicago Dental Society is reported each year.

While we understand the real identity of Dr. Pepys is a dark secret, yet we trust you will convey to the Doctor our sincere thanks and appreciation for the splendid way in which he writes of the Chicago meetings.

Hoping you will do us this favor, I am,

Fraternally yours,

M. M. PRINTZ, *Secretary.*

Chicago, Ill.

To Teach Oral Hygiene in Norway

Miss Anna Sigmond, oral hygienist for Dr. John L. Kelly, Aeolian Building, 29 West Forty-second Street, New York City, following a visit three years ago, has been invited by the Norwegian Government to spend a year there, introducing a course of training in oral hygiene similar to the methods now in vogue in America.

Miss Sigmond is a graduate of the School of Oral Hygiene now connected with Columbia University.

Colonel Oliver Advanced



© Wide World

In 1922, the French government bestowed the Cross of the Legion of Honor upon Colonel Oliver through General Pershing who is here shown pinning the Cross upon Colonel Oliver's breast

According to the *Army and Navy Register*, current changes in the station and duty of members of the Army medical department on account of the provisions of the law with respect to duty with troops and tour of duty in Washington include so prominent an officer as Colonel Robert T. Oliver, of the Dental Corps, who has been on duty since the end of the World War as chief of the dental division of the surgeon general's office and who is now destined to have charge of the Second Corps laboratory, with station in the Army Building in Whitehall street, New York.

He will be succeeded in the surgeon general's office by Lieutenant Colonel Rex H. Rhoades, Dental Corps, now on duty as professor of military science and tactics at the Northwestern University in Chicago. Colonel Oliver may be termed one of the founders of the Dental Corps. From the origin of that branch he has been intimately, effectively and usefully associated with its affairs here and elsewhere. He achieved a notable record in France during the war as an assistant to the chief surgeon of the A. E. F. In Washington he has worked faithfully and successfully for the betterment of the Army Dental Corps, adding to his high professional standing the reputation of an exceedingly competent administrator. The Dental Corps has advanced in efficiency of personnel and in importance of available service under Colonel Oliver.



A Voice for the Longer Course

My Dear Dr. McGee:

IT HAS been with great interest that I have read the series of answers concerning your article, "Back to Methuselah." I read the article at the time of its appearance, but these few words are not directed toward your article, but along with the widespread discussion among the profession concerning the proposed lengthened dental college curriculum.

In all the discussion contained in the dental periodical literature I have failed to find a single instance of comparing the dental curriculum with that of medicine in the manner in which I intend to do. The course of study leading to the degree of M. D. cannot be obtained in any reputable college in less than six years. To these must be added at least one year of internship. Hence medicine requires from seven to ten years of preparation. I would like to ask the calamity howlers if they feel that we suffer a lack of physicians?

Now I will not for an instant retire from the stand on which I maintain that the doctor of dental surgery is equal in dignity and community worth to the doctor of medicine. We of the

dental profession are an integer in the number of men engaged in curing and preventing the diseases of the human body; broadly speaking, we all together form the whole profession of medicine, each caring for his chosen part of the human mechanism. Hence my first contention is, that a seven-year course has not produced a dearth of physicians, nor would an equally long course produce a lack of dentists; and, furthermore, if it requires seven years to make an oculist, an aurist, a laryngotist, so also a stomatologist.

Now to consider another phase of the arguments against a college curriculum in keeping with the dignity of our profession—that of placing dentistry above the reach of the masses. (The masses seem to have some "new friends"—in print.) In the city where I reside the average fee for removing a pair of tonsils is \$50. It does not require any more time, knowledge, labor, nor is any other degree of skill necessary to remove a tonsil than to remove an impacted third molar. Further, the molar can cause as grave symptoms and its removal is many times accompanied with as great risk to the patient as is the tonsilectomy. These same people can always find the \$50 for the tonsil specialist, whatever their cir-

circumstances may be, yet they are reluctant to render the dentist an equal fee for equal service. The "masses" willingly pay the surgeon \$150 to \$200 for a mastoid operation, yet why do they demur when properly compensating the orthodontist for laboring for several years on a case of malocclusion? It is our fault. We have not yet educated the public to their need, nor to the value of our service. For an example: Which is cheaper, the 10-minute \$2 amalgam filling that requires replacement, and repair in a short time, and becomes a trap for food debris, or the anatomical filling, restoring function, self-cleansing, a credit to the operator and a service to the patient, for \$8?

True enough, some of our best operators were graduated in three years, but for every Johnson, Prime and Black there are a thousand who cannot anatomically carve an amalgam filling or properly fill a root canal to save their lives. The men who are taking the four-year course know more and are better operators at graduation than were those who studied three years. Why not? They are better trained, they are reaping more of the benefits of past experience.

If our curricula were not lengthened from time to time, how may our colleges keep pace with the ever-increasing knowledge of dental science? Would our calamity howlers be content with teaching our student the same as he was taught 20 years ago when our sum total of den-

tal science has increased tenfold? Is that the means of progress? Other schools of learning do not consider it so.

I am glad to learn that many dental schools require a year of liberal arts study. As dentists we must serve numbers of college graduates. We must mix with them in social and business life. To do this intelligently we must have an insight into their views of life. If the dentist is to take his place in the community as an equal with the lawyer, banker, physician, etc., he must at least approach these intellectually. Society will not permit this equality unless merited, and a year of liberal arts schooling is the easiest method of accomplishing this.

Personally, I feel that the matter of dental education will ultimately be solved by combining the dental with the medical college for a part of the course.

Whatever adjustment is made will require time and serious consideration by the entire profession. Speaking from experience, I took two years of liberal arts and a four-year course in dentistry. According to one article in ORAL HYGIENE, I wasted two years. But I earned all of my overhead at college, and feel that I received full returns on my time and investment. Hence I feel qualified in a certain way to speak in favor of a longer course, leading to the dental degree, as I have been over the road.

To summarize, dentistry requires an equal amount of skill and knowledge as does medi-

cine; it is as necessary to the public. A lengthened dental curriculum will no more produce a lack of dentists than did the medical course when it was made longer produce a lack of physicians; nor will dentistry be placed above the reach of the masses any more than are the

physicians' services. As a parting shot I might state that the man who is D. D. S. and M. D. usually holds a position as leader among the profession about him.

Very truly yours,

OREN V. SHAW, D. D. S.
Colorado Springs, Colo.

Laboratory Association to Meet

The American Dental Laboratories Association will meet in Chicago on September 15, 16 and 17. A program is now being arranged consisting of an all-star cast. Clinics and papers of interest to laboratory technicians and dentists will be arranged, and this should be by far the most interesting and instructive meeting that has been held by this organization. The definite program will be announced at a future date, and formal invitations will be sent to all laboratories in the United States and Canada. The following are the officers of the American Dental Laboratories Association: J. C. Schwartz, president, Equitable Building, St. Louis, Mo.; E. L. Mueller, vice-president, 1809 Capitol avenue, Omaha, Neb.; W. H. Schroll, secretary, 5 South Wabash avenue, Chicago, Ill.; I. J. Dresch, treasurer, Nasby Building, Toledo, O. Members of Council—J. C. Schwartz, Equitable Building, St. Louis, Mo.; Henry Boos, 608 Nicollet avenue, Minneapolis, Minn.; Samuel G. Supplee, 1 Union square, New York, N. Y.; E. L. Mueller, 1809 Capitol avenue, Omaha, Neb.; B. I. Martinez, 308 Lowry Building, St. Paul, Minn.

"Bravo!" Says Brittain

Dear MR. EDITOR:

Three cheers for a man having real bravery—he says what thousands fear to—Dr. Donahue,* of Dorchester.

I am of the opinion that the folds of his brain secrete a considerable gray substance, also indicating mentality. Let me say that of dentists I personally have known the only two that retired under 50 with more than \$40,000 did the same little things Dr. Donahue speaks of—that is, opened the windows, pushed the broom, etc., and *stuck around*, by the way.

R. O. BRITTAIN, D. D. S.

101 Tremont street, Boston, Mass.

*Page 1016, June (1924) "Oral Hygiene."



Setting Off the Alarm

My Dear Dr. McGee:

Just received the June number of ORAL HYGIENE and have been reading the answers which you received to the editorial, "Back to Methuselah."

I am glad to know that when the alarm clock went off at least eight men were sufficiently awakened to arise, toilet themselves and prepare for the duty of the day, and, not only prepared, but immediately began to function.

Now, with what little light I get on the question, it is not, after all, so much the question as to the length of the course as it is the quality and quantity of the fruitage.

The educational qualifications of an applicant to any profession or calling is not so important as the motive which prompts one to aspire to such profession or calling; if the motive be true and right it matters not whether the individual spends one, two, three, four or five years in college or whether he spends any time at all at college. He will function to the best interest of himself, his fellow-man and his Creator. But if the motive be a little unsteady, not altogether dependable, no man can tell what the consequences may be, nor the time of the happenings.

What I have written not only applies to the dental profession today, but applies to the entire human race as well.

Why should the dental profession today, or at any future period, seek to isolate itself when the lesson which is burning itself into each individual is the fact that all the human race is one common family? If a young man, prompted by pure motives, aspires to our profession, let us all give a helping hand and a cheerful word regardless of what road he may find necessary to take. He may prove to be a chosen prophet, and God forbid that anyone place a stumbling block in the way of the least of these little ones.

Well, Dr. McGee, I wish to personally thank you and express my gratitude for setting off the alarm, "Back to Methuselah." The ORAL HYGIENE has certainly functioned in this particular if it had never functioned before nor ever will again; it certainly fulfilled a mission.

I congratulate you and the ORAL HYGIENE. I know I have not offered any constructive, detailed plan; I leave that to be worked out, each in its day.

Fraternally yours,

J. A. JONES, D. D. S.

Minneapolis, Minn.

Oral Hygiene

The Care of School Children's and the People's Teeth

An Address at the Meeting of the F. D. I. in Paris, 1923

By PROF. DR. MED. ERNST JESSEN, Basle

"Words live on only in the world if they become deeds."



R. PRESIDENT, Ladies and Gentlemen: The Executive Committee of the F. D. I. at Madrid, in September, 1922, decided to hear a report in Paris on the care of the teeth of school children and of the teeth of the people.

In order to have a clear idea it is necessary to know and to examine its first beginnings, its historical development, the work and aims, that which has been accomplished, and that which remains to be done in various countries. We can attribute the first beginnings to the knowledge of the part which an unhealthy mouth pays in the general health of the body, of the propagation of dental disease among the people and its influence on the health of children and the people generally, to those far-seeing dental surgeons who observed these things in their practice.

They called the attention of the authorities, of medical men and professors to the evils then

ignored and absolutely misunderstood arising therefrom, and their effect on the public well-being.

Cunningham, an Englishman, and Röse, a German, deserve to be singled out as among the first who sought to realize this idea with the help of numerous confrères, by introducing dental inspection into schools and into the army with the authority of the governments in all civilized countries—or in giving an impulse to this measure.

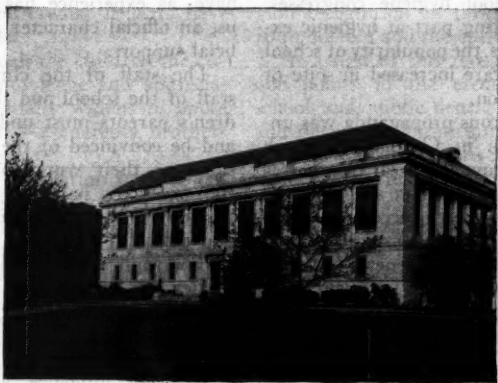
School children and soldiers are the only ones to whom it is possible to apply dental inspection uniformly and systematically.

School children and soldiers are the only classes to which dental inspection can be applied on a uniform plan.

In the '80s of the last century an effort was made to let treatment follow examination in the institutions that we call today school and public dental clinics.

The first beginnings for this were made in Strassburg i/Els, in a private institute at the university for training dental students, and since the year 1888

Across the Water



Keystone Photo

Forsyth Dental Infirmary, Boston

"In the United States of America great legacies have built dental clinics luxurious in display and size, which in the country of unlimited possibilities can be described rightly as the largest in the world.

Clinics such as these are impossible in Europe."

school children and soldiers received systematic and conservative treatment free.

Through this private organization a state university polyclinic for dental disease was formed in 1893, and in the year 1902 the first municipal school dental clinic was founded as an independent institution under the same management as the polyclinic.

Immediately thereafter the Dental Union of the Hessen dentists opened a school clinic in Darmstadt, which later on was

taken over by the town. The school dental clinic in Strassburg, which at the beginning was equipped in a very primitive manner, with the aid of the school and town council through the joint labors of schoolmasters and school doctors, developed from year to year until the year 1911, when it removed into the new building of a large town and medical swimming bath, the rooms of which were for this purpose equipped in a first-rate manner.

As an index of increasing suc-

cess, there were the regular exchanges of the yearly reports to foreign states and town officials, lectures at international dental and school hygiene congresses, and, taking part at hygienic exhibitions, the popularity of school dental care increased in spite of opposition.

Vigorous propaganda was undertaken in Germany through the German Central Committee for dental care in schools, who recorded their proceedings in the Health Commission of the F. D. I. for the benefit of other countries. In the year 1909 they aimed at founding, in as many countries as possible, country committees and national unions, which should act for their part in a similar spirit.

After this short historical survey, we turn to the problems which surround us and the aims which lie before us.

The task of the dental school clinic is to treat all children in free schools, from their entrance to their discharge, from the lowest to the highest form, systematically, the mouth of every single child to be kept healthy by regular examinations, continually repeated after treatment, through the whole school period.

A private clinic has not the means of solving this problem. The school dental clinic must be instituted and must be kept up by the parish, state or city.

Only by official means can a close contact be established between the school staff, the school doctor and the home as is essential for a rational and systematic treatment. All measures and ar-

rangements of the directors of the school dental clinic to treat all the children, and to make them completely healthy, must have, as experience has taught us, an official character and official support.

The staff of the clinic, the staff of the school and the children's parents must understand and be convinced of the importance of their work to obtain the necessary patients for the treatment, which is often trying and difficult.

The younger the children, the earlier the treatment is begun, the easier it is to carry through.

The visit to the clinic must appear to the children to be a reward for diligence, attention and good behavior. The work at and for the clinic should be a joy to all participants; it could be so, if inspired and permeated with good public spirit. On those lines it can add to the education of the young, and only by so doing can it fulfill its tasks and find unconditional recognition and support.

Hand in hand with the treatment in clinic and schools goes instruction about the care of the teeth, and its meaning for the health of the whole body. For that purpose the teachers need enlightenment and papers and school diagrams published by dentists.

Instruction begins by daily practice of personal dental care in the infant schools. The practice of dental hygiene commences — where it is possible — from babyhood, as it is extremely desirable that the children, when

they enter the school, are already possessed of healthy first teeth, should, in consequence of timely and regular treatment, never learn what it is to have toothache.

Through the children the circle of knowledge and appreciation gradually widens to house and family—to parents, brothers and sisters.

After graduation from school the public dental clinics take on a continuation treatment. These are established by the councils, health insurance societies and factories, or linked on with the state dental institutions.

At several universities courses of lectures are given on dental hygiene from the social point of view. It would be advisable that young dentists, after qualifying and before being granted their diplomas, should do practical work for one year in school and public clinics. Various proposals have been made that dental helpers, in the form of clinic sisters, should be made use of to assist dentists in school clinics, and welcomed in the interests of the work.

Norway is the only country in which at present there exists a law which enacts that, after a fixed date, all parishes should introduce school dental care. There this regulation must be carried through by the year 1927. It is recognized that perfectly executed dental care is a source of strength to youth, raises the nation's health, prevents infectious disease, and fights against tuberculosis.

Our aim must be to labor in

common to promote the health of the community; our profession must be placed at the service of social hygienic effort, and gain recognition on this subject from doctors and the authorities.

As a sign of this recognition, one points to the erection of school and public dental clinics and the promotion of our teachers at dental institutions in Germany to the rank of university professors.

It is the task of the F. D. I. to help to carry through these efforts in all countries. Let us examine how far this is done already in various countries, and the methods we have to pursue for the attainment of these aims.

It is, of course, impossible to point out in a short address every isolated fact, and to comment on all names, persons or towns who have brought their whole influence to bear on the question of mouth hygiene. Their number, fortunately, has steadily increased through the course of years. I only can try to point out what has been obtained in several countries through the activity of corporations founded for this purpose. Further material is at my disposal, which it is hoped will be available for future study in the records of the F. D. I.

The public dental hygiene is of international importance, and the basis on which to build it up is school dental care.

Great Britain

In Great Britain the question of school dental care was brought up for the first time at the Brit-

ish Dental Association meeting in Cambridge in the year 1885. Mr. W. Macpherson Fisher, of Dundee, demanded the dental examination and treatment of every single child at its entrance into school and regular supervision by a fully qualified dentist. He repeated this demand at the meeting in 1886 at London, and stated that, in spite of dental supervision, treatment was totally neglected.

In 1890 a committee was put into force which made yearly reports to the authorities. George Cunningham, in Cambridge, gained great merit by doing so. In many schools dentists were appointed. In 1898 the School Dentists Society was founded, which ever has taken the lead.

Their activity was, in a considerable way, supported by the British Dental Association, which made elaborate proposals, through its National Dental Service Committee, in November, 1920, to all state educational and sanitary authorities for the appointment of dentists at maternity and child welfare centers for the treatment of all school children, all adults, tubercular and venereal disease clinics.

Lantern lectures, exhibitions, distribution of popular tracts and instruction in schools were given, having for their aim the education of youth and the enlightenment of the nation.

Two hundred approved insurance societies afford their members dental treatment, and industrial schools and factories

have their own appointed dentists.

Germany

In Germany the Central Union of German Dentists in the year 1861 promised to award a prize for the best work on the care of the teeth and the mouth.

Nearly a generation later Röse gave a fresh impetus by his investigations and scientific works, so that the ball was set rolling on the question of school dental care.

In 1902 the first town school dental clinic was opened.

In February, 1909, the first German central committee for dental care for schools was founded, and in August of the same year the Fifth International Dental Congress in Berlin arranged an exhibition which gave extraordinarily instructive insight on all subjects of scientific dental care.

Through the activity of the Central Committee, a dental journal was published; also various informative pamphlets, lectures with lantern slides, traveling exhibitions, presentations to authorities and advice to parish councils. School dental clinics were introduced by the work of indefatigable general secretaries up to the year 1913 in 195 towns and 14 rural districts.

Large national dental clinics instituted by factories or health insurance bodies undertake after-treatment in various towns. Every university is today in possession of state institutes, attached to which are national dental clinics.

Owing to the extension of health insurance payment in Germany, which today covers all the members of a family, an effort is being made for a working arrangement between the community and the health insurance bureau which manages dental care. The government has means at its disposal to support the community.

Denmark

In Denmark, immediately after the Fifth International Congress in Berlin, preparatory work was taken up through the there nominated Danish National Committee of the H. C. F. D. I., under the direction of Professor Christensen, for the foundation of the Danish Union for Children's Dental Care, January 17, 1910. This union flourished extraordinarily by means of lectures with lantern slides, public assemblies and exhibitions, distribution of pamphlets and memoranda, through articles in school books, in calendars with diagrams for the people, through competitions, philatelic souvenirs for children, and the usage of every possible opportunity for propaganda through the ever-ready support of the press.

In the course of the year school dental care was introduced into 21 towns, rural districts and parishes, in nine institutes for deaf and dumb, orphanages and three private schools.

Various large legacies enabled the Union to erect school dental clinics in 11 parishes by monetary support, which hitherto had

not been attained by any other union.

The proposal to introduce school dental care in every parish after the expiration of five years, so that all children could have free treatment for their teeth, has not yet been fixed legally.

National dental care is in its beginning, through the contracts made between dental unions and health insurance.

Sweden

In Sweden, Förberg and Lenhardtson performed great work when in 1910 the Swedish National Union, for combating dental disease, was founded. The King consented to become the patron of the Union and of the H. C. F. D. I.

These successes were reported in an address read at the meeting of the F. D. I. in Madrid, and lengthily explained, so that special emphasis should be laid upon this point in this memorandum.

Norway

The Norwegian Union for the suppression of dental disease may be proud of one success, not attained up to now in any other country. On December 14, 1917, a law was passed in Norway under which, after the year 1927, all town parishes must give the necessary dental care to all the free-school children. For doing so they receive a special grant from the government, which also will be given to the rural parishes, if they are willing to erect dental school clinics.

Up to now, 40 towns and 22 rural parishes have opened school dental clinics. The education in schools and the enlightenment of the nation goes hand in hand with this.

State deaf and dumb institutions and asylums receive dental care as well. The Ministry of Education appointed a dentist as an advisor, so that all questions could be treated uniformly.

Switzerland

In Switzerland, Brodtbeck (Frauenfeld) has gained special merit for many years through his research work and his example by the introduction of school dental care. He believes that school dental care for children should be paid for by the parents, as otherwise they do not value it. My opinion is that this demand is a great hindrance to the carrying through of systematic general school dental care in Switzerland. Regular national dental clinics, except at the dental universities, do not exist.

Brodtbeck (Frauenfeld) intends to write a detailed work concerning dental care in the Eidgenossenschaft.

In the United States of America great legacies have built dental clinics luxurious in display and size, which in the country of unlimited possibilities can be described rightly as the largest in the world. Clinics such as these are impossible in Europe.

In America in the last 15 years tremendous strides have been made in the overlapping work between doctor and den-

tist for the common welfare. Dental care is legally on an equal footing with medicine, and in all medical research the condition of the oral cavity must be considered.

For the training of male and female helpers for adults' and school children's dental care there are special schools.

School and health authorities, and also the Red Cross, have erected a great number of school dental clinics.

Numerous industrial establishments have dental departments for their workers and staff, to save time and strength. Experience has proved that an increase in bodily health means an increase of working capacity.

In many hospitals, numerous children's hospitals and sanatoria, treatment of teeth is introduced as obligatory.

In France, Belgium, Holland and Luxembourg, in Italy, Spain and Portugal, in Finland, Russia, Austria, Hungary, South America, Australia and Japan, we find everywhere active interest and great will for sacrifice by dentists—eager conversation, singular promising starts of school and national dental care, but not many great practical successes.

The important task, therefore, remains for the F. D. I. to combine with the national unions of the different countries to make a draft of a plan to work in common with the aid of the given examples, to petition state and town officials, to win school and press, and, in pointing to Den-

mark, eventually also to work for legacies.

In the Congress of the H. C., in Madrid, Dr. Piperno, of Rome, made the proposal that the F. D. I. might try to petition for the support of the Carnegie Institute to further its hygienic aims, which are of such great importance for the health of the youth of all countries.

By bringing forward this proposal I ask for discussion, and might I sincerely hope that steps can be taken to bring about the realization of these ideals? If these could be concluded successfully we shall move materially nearer our common aims.

Two resolutions submitted to the meeting of the F. D. I., in Paris, on August 6 to 9, 1923:

Furthering the ideas expressed in the paper about the care of

school children's and the people's teeth, I have the honor to propose the following resolutions:

1. The F. D. I. will undertake to print in a separate leaflet (in one of the Congress languages) its discussions and resolutions and to place it at the disposal of all national societies which intend to make representations to the state and town, education and health authorities, also to national health insurance and factories of their respective countries, for the introduction of the care on school children's teeth and public dental service.

2. The F. D. I. request their president to become chairman of a specially elected commission to inform the Carnegie and Rockefeller institutions about the aims of the F. D. I. and perhaps to beg them to foster their aspirations.

Italian Dentistry and Mussolini

Dr. Eugene S. Talbot, of Chicago, touring Europe, sends ORAL HYGIENE from Paris a splendid article dealing with the remarkable overnight regeneration of Italian dental education. Dr. Talbot's story of the labors of a great Italian dental educator—his success in enlisting the support of Mussolini, and the fruition of his dream—is a new chapter in international dental history. It will appear next month.

The Drainage

By C. EDMUND KELL



VERY now and then some dental writer, while discussing the treatment of alveolar abscesses, will refer to the methods used by surgeons in handling the abscesses which come under their care. As a matter of fact, such references are merely a waste of words, because they are not at all pertinent to the question at issue, and, *as a rule*, merely serve to show that the writers themselves are not at all conversant with good surgical procedure of the present day.

In the first place, the conditions surrounding an alveolar abscess are not duplicated in any other part of the body; consequently, all abscesses met with by the general surgeon must necessarily be treated in an entirely different manner from that which would apply to the abscess within the jaw.

One of the statements to which I always take exception is that an abscess upon a lower bicuspid, let us say, can be *drained*, and the fact that the surgeon drains an abdominal abscess "straight upwards" is cited to prove his case.

To digress a moment. A few years ago all kinds of dentists—college professors and all—spoke continually of "dead teeth." "Dead teeth" was a term handed down from generation to gen-

eration. It was merely an heirloom in our vocabulary, and it was a senseless term, as it did not mean what the words really implied.

However, no harm came from the use of the term, because dentists and physicians alike had a certain amount of respect for the "dead teeth," as they were termed, and all possible efforts were made to save them.

Suddenly, like a flash of lightning out of a clear sky, a *dead tooth* took upon itself a real significance, and then dentists realized their mistake in applying the word "dead" to a tooth which was not dead at all. Then, just as suddenly, they changed over to the word *pulpless* tooth to describe a tooth in which the pulp was dead. No longer does the intelligent dentist use the term "*dead tooth*."

Some few writers use the word "non-vital," but that, of course, is also a misnomer. The "*pulpless tooth*" is the only *correct* term that can be used today.

So much for the digression. Now, then, to resume. Just as the term "*dead tooth*" has been used in dentistry for ages to designate something which *it is not*, so has the word "*drain*" been likewise misused for ages, by the medical profession, to designate something *which it is not*.

"*Drain*, to drain off utterly. To cause the exhaustion of. To

Age of Abscesses

D. S., New Orleans, La.

draw off by degrees. To make gradually dry or empty." (Webster's International.) That is what the word "drain" means.

Now, friends, words — yes, words — really do mean something, and when the real definition of the term "to drain" means "to draw off utterly; to cause the exhaustion of; to empty," anyone can readily recognize the fact that the usual surgical *drain* does not do this, and, consequently, not doing it is no *drain* at all.

It does not empty any cavity in the body of any fluid that is in the cavity. It is no drain. It is merely a drain in name. Surgeons really do not drain abdominal abscesses "straight upwards."

The "dead tooth" and the surgical "drain" are in the same category — that is, they are myths, if you please, or, if not myths, then just plain misnomers.

Now, then, if drains *do not drain*, then what do they do? Well, if we are allowed to call this thing, which is *not* a drain, a *vent*, which it really is, then the whole problem is solved.

No surgeon needs to drain wounds straight upwards, nor can he do so. All he does is to put in *vents*, which allow the *surplus accumulation* of fluid to ooze out; the *oozing upwards*

against gravity being caused by the pressure from below.

The abscess cavity is always full of fluid — never drained, never emptied as long as the fluid is being secreted.

Dame Nature, without whose aid no abscesses could be cured, lends a hand, the formation of the pus ceases and then the wound closes up.

And now, how does the surgeon of today look upon the *vent* (which he calls a "drain" just because his grandfather called it so) as compared to his viewpoint upon it some twenty years ago? Well, he looks at it from an entirely different aspect, let me assure you.

Twenty years ago good surgery required 100 per cent of all abdominal operations to be "drained." Today let us see what good surgery requires.

Twenty years ago the removal of a tubercular kidney was followed by drains and packs, and the death rate of the operation was high.

Today the surgeon removes this kidney, fills the cavity with saline and *sews it up*. Never a drain — and the death rate is very much lower.

Twenty years ago, when the fallopian tubes were removed, 100 per cent were drained.

Today not 4 per cent of such operations are drained.

Twenty years ago, when there

were effusions in the knee joint, they were cut into and drains put in.

Today such knee joints are not cut into at all. They are only aspirated with a needle—nothing more.

Do you know that 20 years ago secondary infection, caused by the drains and packings, was an everyday occurrence?

The omission of the drain eliminates this secondary infection.

Twenty years ago drains were inserted in all appendectomy operations. Today the surgeon cuts down and exposes the appendix, cuts it off and cauterizes the stump (phenol, or the actual cautery—whichever the surgeon himself prefers) and sews up the abdominal wall in 80 per cent of his cases.

Twenty years ago, in all gall bladder operations, drains were inserted. Today drainage is employed only in cases showing acute manifestation of disease and where there is the likelihood of a soiling of the peritoneal cavity. It is also employed where the pathology has extended beyond the gall bladder and involves the pancreas and liver, to give vent to pent-up infectious material.

Twenty years ago, in all operations for abdominal tumors, drains were used. Today they are employed only in a very small per cent of cases.

Surgeons are gradually using vents less and less, and the day will probably come when they will be practically eliminated except in instances of contamina-

tion or in the presence of an active infectious process.

Thus we see that the so-called "drainage" of surgical wounds has been largely eliminated during the past 20 years. What about alveolar abscesses? The same *progressive* change has occurred in dentistry as has taken place in surgery, as just stated.

When I began practice, the treatment of alveolar abscesses by inserting medicaments upon cotton dressings—vents, not drains—was the accepted procedure. We would treat abscesses for from three to six weeks or longer, changing the *dressings* frequently.

Then a change of procedure was suggested, and the *immediate* filling of putrescent root canals was taught. Some men adopted this new method at that time. Many did not. (Fortunately, I was one of those who did.)

Today, however, many of those who still believe in *treating* abscesses have reduced the number of treatments to two or three, and some day let us hope that they will be able to recognize the fact that no treatment whatsoever is needed to eliminate alveolar abscesses; that putrescent pulp canals can be successfully filled today at one sitting, *just as was taught by Cassius M. Richmond over forty years ago*, and being thus taught by him I, for one, have followed the practice ever since.

Richmond was a true disciple of the immortal Ambrose Paré, who lived nearly four hundred years ago, and who wrote: "Je

le Pensay et Dieu le guerit"—"I dressed him and God healed him." *

And so it is with the alveolar abscess of today as it was with Paré in 1552, only I would paraphrase the sentence and have it read: "I *treated* the abscess and, in spite of the treatment, God healed it."

It is not possible, in a little paper like this, to go into the details of why alveolar abscesses, which cannot be drained "either up or down," fortunately, do not need to be drained at all.

To digress again. I wonder if many of the readers of ORAL HYGIENE know what the dentists "used to do" to teeth when patients presented, complaining that a tooth was "sore as a boil," and which contained a *confined* dead pulp? I reckon few of them do know, and so I shall tell them all. They would take a small drill or bur (this was before the days of the dental engine, you must know), push it up just under the free margin of the gum, and then straighten it up and drill right through into the root canal. That's what they did, and they did it because it would afford relief. Was that making a drain? Not on your life! It was making a *vent*.

I, myself (old timer that I am), have made such a vent lots of times in *deciduous teeth*, and would do it again tomorrow if a case presented in which the procedure was warranted.

Wasn't Cassius M. Richmond a wonderful man! Way back

in 1884 he knew that alveolar abscesses *could not be drained*. He knew that they did not require drainage. He knew that removing the putrescent contents of the root canal, sterilizing the canal and filling it at once with an *antiseptic* filling material was all a human being could do towards curing an alveolar abscess.

Forty years of the rather successful practice of *his* methods have given all those who have had the "nerve" to follow his teachings ample evidence of their having been founded upon correct principles.

Anyone who today *treats* abscesses by putting in so-called "drains;" who treats abscesses by putting in dressings; anyone who "fools away" his time by such methods, is just forty years behind the times. Anyone who doubts this statement need only look at Fig. 32, read its case history (page 408, *Cosmos*, October, 1923) and be convinced, as were the two young men whose case it was. That tooth is in good condition today.

Two Methods of Practice

Not so long ago there appeared in one of our journals an article on root canal procedure. The treatment of *infected* root canals was referred to, and the following is taken from the paper in question:

"This dressing should, if possible, be changed every day for the first week, and then for the *remaining two weeks* (italics mine) should be changed according to the indications given

* "Soul of the Surgeon," by Dr. Rudolph Matas.

by the drainage upon the cotton dressing."

Now, then, a patient living some distance—say two or three hundred miles—from such a dentist must necessarily go to his city and remain there for at least three weeks, and possibly four, in order to have an infected pulp canal treated. Three or four weeks' time lost by a business man—if such he should happen to be—and hotel bills, etc., added to the cost of the treatment. Can you imagine any dentist of today carrying on a practice on such lines? Well, any dentist following such methods is just forty years behind the times.

On the other hand, such a patient could go to a modern dentist and have this infected root canal filled in either one or two days.

One day last week a lady living in the country some hundred miles and more away came to town and went to her dentist, by appointment, early in the

morning. She had broken off the crown of an upper lateral and it was a pulpless tooth.

The dentist opened into the pulp chamber and root canal, sterilized and filled the root canal, made and inserted a porcelain-faced crown, and she left for home that evening. And this dentist did not do anything out of the ordinary at that.

I stop writing for the moment and go out upon the lawn this beautiful evening for a "breather," and, looking up into the sky, see the thousands of glistening stars, think of the immensity of space, and say to myself, "I can't understand it all."

I return to my desk, turn to such a paper as the one just quoted from, and read how abscesses are now, at this late day, "drained upwards," and for three or four weeks at that; and again I say to myself, "I just can't understand it all."

The *immensity* of the one; the *density* of the other—they are both too deep for me.

The Dental Chautauqua

Editor ORAL HYGIENE:

In your May, 1924, issue I have just read the article by Dr. C. Edmund Kells, New Orleans, La., captioned "Dentistry—Yesterday, Today, Tomorrow," and under the sub-caption, "The Dental Chautauqua," found my own name and reference to the plan for a dental chautauqua which I, as president of the old Southern Dental Association, presented to the members at the meeting at Lookout Mountain, Chattanooga, Tenn., about thirty-five years ago.

I am still in favor of the American dental chautauqua and am

very desirous of actively pushing its creation and organization, and to this end beg to enclose you a copy of my letter, of even date, to Dr. Kells, which I feel sure, if published in your journal as a supplement to Dr. Kells' article, will help the chautauqua on its way.

Yours truly,

W. H. RICHARDS, D. D. S.
P. O. Box 105, Knoxville, Tenn.

Dear Dr. Kells:

From the date line you will see that I am visiting relatives in Bloomington, Ind., having left my home before receiving our current

professional literature and was not aware of the compliment you paid me in the May issue of ORAL HYGIENE, by reviving the idea of a dental chautauqua which I set forth years ago at the meeting at Lookout Mountain, Tennessee, in the presence of some still living and of many who have since passed beyond, notably Doctors Morgan, Crawford, Taft (then dean of the Cincinnati Dental College) and Catching (then editor of the *Southern Dental Journal*), who published a digest of my speech; these would, if reincarnation were possible, no doubt be unbouedly enthusiastic over the revivification of the plan.

You have a general reputation among dentists for initiative, practicality and execution, and I find that the members of the fraternity here and elsewhere read, re-read and copy articles from your pen and practice your suggestions. The position you occupy in the mind of dental America puts you in line to hold widespread attention and to secure the adherents necessary for development and materialization of the idea I set forth 35 years ago. I am certain that your earnest and enthusiastic desire to accomplish the utmost in professional advancement, for our every confrère, will so function as to enable you to build an institutional clinic upon an old idea and to so perfect it as to glorify the entire personnel of our profession by the results attained.

My conviction as to the fundamental need of a permanent dental chautauqua as contrasted with the impractical brevity of convention clinics has remained constant for the past 35 years, and I am, therefore, in complete accord with your plans and desire to be of every assistance. In connection: I expect to attend the Indiana State Convention, Indianapolis, Ind., May 19, 1924, and to avail myself of that opportunity to outline the subject as you set it forth and to follow up the opening thus created by distributing some typewritten ideas on the subject which, I feel certain, will help to impress the idea forcibly. I will endeavor to enlist the aid of all

members present, persuading them to personally present the proposition to their friends and thus quickly spread the plan and open an active campaign at once.

To promote the organization of such a chautauqua, I shall remind the members that a plot of land near the Biltmore, North Carolina, estate—a part of which was bought from the Vanderbilts by the government for park purposes—may be secured from the United States on a 99-year lease by any responsible parties who will beautify their leased location with fine residences, club buildings, etc. This beautiful park will be made entirely accessible by superb government and state-built highways which will make intercommunication easy and motoring a pleasure.

I expect to suggest the creation of the following departments, dedicated to improvement in methods and technique, to be permanently housed in some chautauqua buildings to be erected and equipped especially for the purposes of research, experiment, instruction and administration in—and of—all specialized departments of dentistry.

Supplementing that, I will strongly suggest and urge, for the benefit of the fraternity, that there be selected from our ranks those of our confrères who, by long years of experience and practice, have proved themselves the most eminently fitted to teach the rest of us that technique which has lifted them into the limelight in their chosen department of the profession, and that such men be appointed to positions as instructors, clinicians and assistants, and that they be authorized to lend their assistance, either by thesis or by practical application of advanced appliances, to any who may be introducing advanced information.

The present members of the American Dental Association can materialize this visualization practically without effort by paying one and one-half cents per day, or \$5 each, for the first year of membership—thereby providing capital—and \$1 each every succeeding year

—thereby providing maintenance—neither of which sums would be a hardship on the least prosperous member of the whole Association. The money thus secured will not be our ultimate financial expectancy, however, for it will be the privilege of each charter member of the American Dental Chautauqua, working in his own section, to secure as members every dentist who is not a member of either district, state or national association, or who does not attend conventions, or who does not subscribe to dental periodicals, attracting them with the manifold advantages available both by study and from the research which will be continuously conducted by permanently employed institutional dental scientists and from the vacation advantages afforded on the grounds of the chautauqua, in the form of swimming, tennis, golf, motoring, hiking and radio. There should be at least two membership plans for those not charter members:

(a) A limited term of instruction, at the chautauqua grounds, each year for new members for a fee of \$10 per year, and

(b) A life membership in the chautauqua for a fee of \$25.

I am enthusiastic about two other ideas, and propose that the chautauqua be adopted as the permanent site for our yearly dental conventions, thus bringing all dentists to one place, and that the chautauqua be selected as permanent location for the publication of the *Journal of the American Dental Association*, moving the printing machinery and personnel from Chicago, which will produce two desirable results:

(a) Lower cost of producing the *Journal*, and

(b) Prompt and comprehensive publication of the results of our institutional research work.

I purpose to stress a point I made at Lookout Mountain, and that was the importance of creating archives wherein records of the accomplishments of the deceased will have a permanent home, and to which the living may bequest funds, instruments and data which are now being lost, but may thus be saved to the perpetuation of dental science, and will prove a providence that will inspire the profession to a continuous record of more striking and abundant achievement than we have produced in the past.

We can formulate other major and all minor details after presenting the plan at the Dallas (Tex.) meeting, and there inaugurate the movement necessary to make the chautauqua a fact.

As an appreciation of your courtesy, I wish to mail a copy of this letter to ORAL HYGIENE for publication if such meets with your approval. Kindly wire me care Claypool Hotel, Indianapolis, Ind.

With my personal regards and expressions of best wishes and trusting to see you at the national meeting in Dallas,

Yours sincerely,

W. H. RICHARDS, D. D. S.

N. B.—I will suggest to the Indiana State Association that they appoint, at the May 19 meeting, a special representative for the Dallas meeting, such dentist to be one of the number to be selected by each State organization for the promotion of the American Dental Chautauqua.

P. O. Box 105, Knoxville, Tenn.



IDEAS for Hygienists

By JOHN PHILIP ERWIN, D.D.S., Perkasié, Pa.

Part VI.—Trumps and Tricks of Teaching Tooth-Truths



CONFUCIUS said, "Do not do unto others what you would not have them do unto you."

That was a negative maxim. It told men what they should *not* do.

Five hundred years later Christ reversed that advice into positive form. He preached, "Do unto others what you would have them do unto you."

That was a step forward in pedagogy.

Came Saint Paul. He was familiar with the methods of both these famous teachers. Profiting by this knowledge he combined the positive and negative into the conjoined form, the climax of assertion.

Saint Paul's favorite form was, "Rejoiceth not in iniquity, but rejoiceth in the truth." "For the kingdom of God is not in the word, but in power."

He would teach, "Do not do unto others what you would not have them do unto you, but do unto others what you would have them do unto you."

It is extremely interesting, and helpful to all ambitious souls, to observe how Saint Paul's immortal epistles fairly over-run with *buts*. His writings reveal the ultimate in pedagogy.

Would you markedly improve your teachings — increase your "selling" powers?

Would you have your speech, your writing, your conversation impress clearly, forcibly, permanently?

Study the methods of Saint Paul. Observe how he obtains clearness by showing all sides of his proposition. Notice how he forces thoughts indelibly upon your mind by telling *what they are* not and *what they are*.

Strange, modern American writers use this method but little. French and German authors less. English scribblers much, to wit, H. G. Wells and George Bernard Shaw.

There is one American, however, who is master of conjoined assertion, namely, His Excellency, the President of the United States, Calvin E. Coolidge.

Say What You Mean Mean What You Say

Here is a valuable suggestion for the use of the foregoing principle. (Keep in mind the three elements for which we are striving, namely, force, clearness, permanency. Without them we fail. With them we succeed.)

When teaching oral hygiene lessons express negative assertions with frowns, disgust, harsh-

ness, antipathy; positive claims with smiles, sweetness, pleasure, delight.

Be intensive. Act your part. Characterization carries conviction.

Practice this suggestion with the following examples:

You don't want *dirty, ugly* teeth. No! You want *clean, pretty* teeth; teeth like pearls.

Dirty, ugly teeth make you frown and pout. Clean, pretty teeth make you smile and happy.

Frowns and pouts and ugly teeth never won a friend. The iciest heart quickly melts before a pearly smile. It is irresistible.

Boy + poor teeth + sick stomach = weak man.

Boy + strong teeth + sound stomach = strong man.

No one loves a toothless girl. Everybody admires the maid with a pearly smile.

Try this one on your school board or board of health: Dental *cure* is obsolete. It fails to meet present-day demands. It is too slow, uncertain, costly, painful, destructive. *Preventive* dentistry is ideal. It insures dental efficiency. It saves dollars and patience. It promotes robust, vigorous health.

Here is a fact which will help you to a better understanding of the use of the above lesson.

Negative assertions push,

goad, drive, impel. They get behind a sinner and force him into action.

Positive assertions lead, coax, lure, entice. They create an insatiate desire. They charm.

Naturic: when you push a stubborn person would you smile? Surely, to entice, you would hardly frown. Get the point?

Queer, human nature. I was just working for a seven-year-old girl who refused to open her mouth. She was not ugly nor cross. She was not particularly afraid. But for some reason she pinched her lips tight shut.

When I sensed the situation I said nothing. I waited. And waited. Had I tried to *force* her we would have had a battle royal.

After several minutes of perfect quiet I smiled as though pleased and suggested slowly in a soft, clear voice, "My, how nice you open your mouth. That is fine. You open better than mamma. Now I can see to fix your teeth."

What do you suppose happened? Yes, she opened so wide I could have stepped inside. Why? Because I led her with smiles and positive suggestions.

(To be continued)



Editorials

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Conventions

HEVER since Noah and his sons went into the boat business, conventions have been popular. Probably that is why we call old customs "conventional."

One very noticeable thing about conventions is their resemblance to poor relations — a lengthy visit is not appreciated. In fact the second week of effort is almost as disappointing as is the first week when there is no contest.

Now that the two great quadrennial gatherings of delegates are over and the candidates named, every member of our profession should realize that his or her vote is exactly as important as any other vote.


Every loyal citizen should consider it a solemn duty to register and vote. If you don't vote you place yourself in the

position that is so unpopular with the subjects of absolute monarchs.

Did you ever think of the age-long struggle that humanity has made for the privilege of voting? Oppression, slavery, revolution, civil and international war have time and time again been endured for the simple privilege of voting and yet we, as a nation, and I might almost say we, as a profession, pass lightly by this valuable right because it is too much trouble to conform to the many regulations that have been enacted partly to safeguard the ballot and partly to discourage the faint-hearted.

Let us take more interest in public affairs so that when dentistry has a favor to ask, the powers-that-be will realize that every dentist is a thinking voter.

Vaccination

HROUGHOUT the United States there are scattered epidemics of smallpox.

A few cases in one community would not be a cause for undue anxiety but when the health reports show a widespread tendency to infection, it is time to submit and to encourage others to submit to the one prophylactic that has given immunity to smallpox, and that is vaccination.

The Summer Vacation

IS there any particular reason why education and warm weather won't mix?

With school children, a summer vacation is simply a concession to the prehistoric instincts of the race to be free to roam or play or loaf.

When the child is old enough to study a profession, there is no good reason why he should not stick to learning as closely as he will to practise. Certainly after graduation there is not likely to be three or four months' freedom from work every summer.

It would be a great saving of time and expense to conduct an eleven and one-half months' course each year and shorten the length of time accordingly. This would result in less expense of time and money to the student and better results for the money invested in college buildings and equipment.

Concentration of the course rather than mere extension is what is needed.



Why So Much Decay in Bicuspid and Molars?

By JOHN LOUIS HELMER, D.D.S., Indianapolis, Ind.



TOOTH decay has greatly interested me ever since I graduated from dental college in 1902; and when the feature of the lack of proper vitamins in our diet is promulgated as the prime factor in tooth decay it raises the question in my mind as to the soundness of the logic.

Of course, I realize the step forward of science when the vitamin factors in foods were discovered.

Our diet should be regulated so as to include the proper and sufficient vitamins. Vitamins and diet should be studied at the same time. I believe that lack of vitamins in diet has very little to do with the decay of teeth.

In my practice I find most of the decay of teeth originates in the grooves or sulci of bicuspid and molars, and I believe that you will agree with me that more decay is found in the bicuspid and molars than in the anterior teeth, and that most of the decay commences in the sulci of these teeth.

Enamel starts to calcify at certain definite places in a tooth. These points of calcification might be termed islands of calcification. As these islands of calcification become larger and

larger as the lime salts are deposited, they come together and form at the junction of the grooves or sulci on the occlusal surfaces of the teeth.

If these teeth were properly and completely formed, the islands of calcification would coalesce and unite into one solid enamel, but where these islands of calcification did not coalesce there resulted small cracks, fissures or clefts. Why do these islands of calcification sometimes coalesce and sometimes do not?

I am not sure that I know why, but I have an opinion which I wish to state.

My opinion is that there is a faulty rudimentary enamel organ to start with. The epithelial sac which formed the enamel organ was lacking in its continuity; there were these fissures or clefts in the rudimentary enamel organ before calcification started. And my opinion is also that the faulty rudimentary enamel organs are handed down from generation to generation, skipping a generation now and then.

Mothers have often asked me, "Why do my children have so much decay; they brush their teeth regularly and keep them clean?" It was true they did brush their teeth regularly and

would have kept them clean had it not been for these fissures or clefts. No toothbrush could gain access to these clefts sufficiently to effectively clean, so the tooth decayed in spite of very diligent care. My reply to the mothers has been "How are your teeth, or how about fathers' teeth?" Often the reply would be, "Oh, I lost my teeth when I was real young; they were too soft to hold a filling and they had to be extracted."

Or possibly it was the father who lost his teeth when he was young.

Sometimes the parents would have exceptionally sound teeth and their children's teeth would be badly decayed. I believe in these cases the feature of inheritance has skipped one or more generations.

For we know from the study

of eugenics that traits, physical marks, color of hair and eyes, cleft palate and harelip may crop out even after the third or fourth generation.

With all the different vitamins, and even with a proper diet, lime salts can be deposited as enamel only in the rudimentary enamel organ, and where the rudimentary epithelial sac lacks continuity we will find the same lack of continuity in the completed calcified enamel.

Into these small clefts food will be crowded, which, decomposing, will result in dental caries. It is sure to happen if fillings are not resorted to as a prophylactic measure.

The author has never seen non-carious tooth structure too soft to hold a filling if the cavity preparation was properly made.

Dr. Hinman Receives Honorary Degree

By NATHANIEL G. SLAUGHTER, D.D.S., Athens, Ga.

On Wednesday, June 18, 1924, the University of Georgia conferred upon Dr. Thomas P. Hinman the honorary degree of Doctor of Science.

I think that this is the first time that a member of our profession has been thus honored by a great southern university.

In making the presentation, Chancellor Barron paid a beautiful tribute to Dr. Hinman for the great work he has done for the advancement of dental science, and to the progress dentistry has made in recent years.

It is an epoch in our history when one of our men is honored in this way, and I trust it may be an inspiration to many of our young men to strive a little harder to place our profession on a more scientific basis and to catch a greater vision of our opportunity to serve humanity even more efficiently than we have in the past.



About the Libby Article*

Regarding Six-Year or First Permanent Molar Extractions

By MOSES JOEL EISENBERG,
D.M.D., Roxbury, Mass.

Fellow of the Harriet Newell Lowell Society for Dental Research of the Harvard University Dental School; Chief in Dental Orthopedics at Forsyth Dental Infirmary for Children, Boston, Mass.



SCIENCE is above controversy, and dentistry in all its branches is a science.

I am rather abash at entering into a discussion that makes me bristle all over, since I love and respect Doctors Henry and Arthur Libby, of Boston.

I enjoy their personal friendship and contact, and were it not for the fact that I am taking up this discussion from an impersonal viewpoint I would never dare offer my opinions.

This matter of ruthless removal of six-year molars to make room for the other permanent teeth is to me an indication that dentistry is still in its elementary stages of evolution. I have, by virtue of my associations, seen the results of cases of countless children where the first permanent molars were re-

moved for a real cause and where considerable distortion was caused—that over-mesial tilting in the second molar region and the distal drift of the second bicuspid.

I agree with the Doctors Libby that the number of children requiring regulation is on the incline—but that can be handled from a much more efficient and scientific angle.

I agree that the number of dentists majoring in orthodontia is not adequate to really help in the dilemma; also, I grant you, that a large number of children are therefore neglected. I hope to show how education and dieting, dental orthopedics and a scientific application of its teachings will remedy the serious conditions that are alarming the thinking man in the dental profession.

To correct any deformity, dental or otherwise, requires a recognition that a deformity exists and a knowledge of the points involved in this deformity. The deformity that exists in the dental arches are of underdevelopment, and not an oversupply of teeth.

The parts involved are the dental arches that invest the teeth, not the teeth themselves. The teeth that reflect the irregularities are plain victims of circumstances and are individual objects that are jumbled according to the forces applied to them,

* "A Simple Method of Correcting Irregularities of the Teeth," by Henry F. Libby, D. D. S., and Arthur A. Libby, D. D. S., Boston, Mass., page 1027, June (1924) "Oral Hygiene."

correctly or incorrectly, through the jaws.

It seems rather unfortunate that under-development of the jaws necessitates the removal of four very important masticating teeth.

Also there appears this rather interesting fact: Doctor Angle has stressed to us the value of the first or six-year molars as the key to occlusion. In the deformities of the jaws and teeth the Class 1 cases seem to be most abundant, because it is the segment involving the cuspids and bicuspid that is most often at fault. It is the argument for correcting deficient development in the anterior region that is most needed and not the removal of the first molars. Such removal will not stimulate nor simulate anything like proper natural development, because it at once invites mesial drift of the second molars and distal drift of the other superior teeth, causing such deformities as we have seen many times over, including traumatic occlusion and sparse or inefficient contact points of the individual teeth.

In these enlightened days, when the study of histology and pathology open up and reveal fields of endeavor to the eye of the dentist, such correction is rather indiscreet and unscientific.

If removal of teeth is the only salvation, why not sacrifice a bicuspid in preference to a molar? There the number of inclined planes involved are less and the amount of disturbance created also much less.

Removal of teeth, however, is not the best way to solve this orthodontic bugaboo. I feel that preventive measures are the only safe and sane methods.

The consideration of the possibilities of jaws holding temporary teeth failing to develop properly so as to enlarge sufficiently to accommodate their permanent successors is the solution.

This realization, coupled with the fact that in my clinic at the Forsyth this practical phase is corrected by inexperienced internes, makes the argument for extraction much less. I will grant the Doctors Libby that there are a number of cases so progressed in years that orthodontic treatment is impossible. Extraction of the six-year molars in such cases might be of some value if the loss of the teeth will give a more efficient occlusion. Dental orthopedics takes for its object the prevention of malocclusion in the permanent teeth by a study of the temporary teeth.

This study consists of placing a numerical value on the temporary arch. To this numerical value is added an arbitrary average figure which represents the difference between the average temporary and average permanent arch in the same individual. This result will represent the numerical value of the permanent arch for the given case. I feel that prevention is the only way in which the alarming increase in tooth extraction may be curbed.

Diet regulation, as outlined

by the results obtained by Doctor Percy Howe in his classical studies on the monkey at the Forsyth Infirmary, is the key to dental growth and development. For if the materials used in the making of any structure are below par and are questionable as to resistance-building powers, the completed structure is never any stronger than its weakest support.

The Method Little Understood

By L. H. TATE, D.D.S., Canton, O.



AFTER reading the article in the June issue by the Doctors Libby, entitled "A Simple Method of Correcting Irregularities of the Teeth," am of the opinion that it should have some attention, for, as the Doctors have said, it is a matter of grave importance. Have come to the conclusion that I would like to put a few questions to anyone who might be seriously attempting the correction of malocclusion by this method.

If the dental arch is inclined to get smaller from generation to generation, and if Nature is making an effort to reduce the number of teeth therein, would you aid or hinder this natural process of eradication by the extraction of the first molar, it being one of the teeth that is seldom missing?

Would it not be better to teach the school child the combinations of food that will produce the correct amount of bone and other tissue-building materials,

that the prospective mother, and the mother, may eat and teach the child to eat in a way that will greatly reduce the percentage of this tendency, as well as grow a better quality of teeth and a better developed human machine in every way?

What is the condition of occlusion in the mouths of your patients who have lost one or more first molars at any age and received no orthodontia treatment? Is the percentage of decay more or less? And what is the condition of the gums compared with those not losing any teeth at all?

Is it more or less difficult to construct and manipulate an appliance of any kind for the correction of malocclusion where the teeth are all in the mouth or where the first molars are lost, either part or all of them? Which will require the greatest amount of time? Which will give the best results?

The authors have correctly stated that this method of treatment is little understood by the profession. Therefore it is to be hoped that no one will pitch his old Panama into this ring until after giving the matter considerable consideration from its different angles, and then let his conscience be his guide.

A Philadelphian's View

By JAS. F. COLL, D.D.S.,
Philadelphia, Pa.



ASIMPLE Method of Correcting Irregularities of the Teeth," by Henry F. Libby, D. D. S.,

with Arthur A. Libby, D. D. S., qualifies itself in its last paragraph for the reason no dentist of any experience and knowing the justice of square dealing with the little ones would question the helps toward a method for the greatest good to the greatest number; and those who would question are apart from the text "that we grow weaker and wiser" and must fashion our methods accordingly in physical treatments.

Unfortunately, the general advocacy of removing the first permanent molars to ease the contour of the upper and lower jaws carries the nasty risk of permitting the second permanent molars to tilt from want of resistance in proportion as the third molar is seeking position.

The front lower teeth are more irregular, in many in-

stances, from a too long retaining of the first or temporary cuspids, and many of the little ones suffer from the wedged second temporary molar, which ought to be removed.

Experience has proved that it is good practice to open the first permanent molar, remove the nerves and widen the apertures of the canals and stone down the distal walls in order that everything is wide open or saucer-like; then stain the whole area with a 10 per cent solution of nitrate of silver, thus protecting the second molar and allowing it to crowd and break up the first molar as it seeks space for the erupting third molar.

The Doctors Libby are to be congratulated for their spirit of social justice insofar as dentistry may contribute, but I am sorry they put in that last paragraph.

Next Month:

Physical Culture of the Gingivae

By PAUL R. STILLMAN, D.D.S.,
F.A.C.D., F.A.A.P., New York City.

Laffodontia

If you have a story that appeals to you as funny, send it in to the editor. He may print it—but he won't send it back.

"What do you think of your new little sister, darling?"

"Well, she's sure a dandy ad f'r pyorrhœa!"

On his tour of the district an inspector of city high schools came before a class of girls. He wrote on the blackboard, LXXX. Then, peering over the rims of his spectacles at a good-looking girl in the first row, he asked:

"Young lady, I'd like to have you tell me what that means."

"Love and kisses," the girl replied.

BRIDE (consulting cook-book): "Oh, my, that cake is burning and I can't take it out for five minutes yet!"

TEACHER: "Johnny, give me a sentence using the word diadem."

JOHNNY: "People who drink moonshine diadem sight quicker than those who don't."

MISTRESS: "Mary, your young man has such an air of braggadocio about him."

MARY: "Yis, pore lad, he worruks in a livery stable."

JACK: "Would she let you kiss her?"

CHAN: "Oh, heavens, no! She isn't that kind!"

JACK: "She was to me!"

KIND OLD GENTLEMAN: "Did 'ums break 'um little dolly?"

SWEET CHILD: "Yes. Why the hell do they make the damn things so fragile, anyway?"

"Nigger, did yuh come by dat derby honestly?"

"Uncle, I done come to it honestly, but dass all."

A dear old lady had bought a canary, which sang sweetly for a while, and then suddenly relapsed into silent, brooding melancholy. She went back to the store where she bought it and made complaint.

"Your bird wants a mate, madam," replied the dealer.

"Is my bird a male or a female?" she asked.

"Really, I can't say. You will have to find that out for yourself."

"But how can I tell?"

"Why, very easily. All you have to do is get two worms, a male and a female, and put them both in the cage. If your bird is a male it will eat the female worm; if it is a female it will eat the male worm."

"But how can I tell a male worm from a female worm?"

"Madam," replied the dealer, politely but firmly, "this is a bird store. You will have to get that information from a worm dealer."

FRIEND (accusingly): "I didn't see you in church last Sunday."

GOLFER: "No, I couldn't go. It didn't rain."